Host Hospital Checklist for Sending and Receiving Provincial Airvos™ 2 Nasal High Flow Device

To be completed prior to the Airvo™ 2 Nasal High Flow Device shipping and upon return

Please complete one form per Airvo™ 2 Nasal High Flow Device

Date: _____ **Completed By:** _____

Host Hospital Name: _____

Site Lead (Name and Title): _____

Contact Number and Email: _____

Airvo™ 2 unit being (check one): ☐ **Shipped** ☐ **Received**

Requesting Hospital Name	Requesting Hospital Contact Name and Number
Type of Unit	**Date Shipped / Received**
Airvo™ 2 Nasal High Flow Device	

MOH Asset Tag Number	Hospital Tag Number	Serial Number

Action	Status	Date	Initials
Vendor information on the Airvo™ 2 unit	☐ **No** ☐ **Yes**		
Biomedical electrical check	☐ **No** ☐ **Yes**		
Passed the following tests: Heaterplate Check for leaks Check for blockages Check tube Power out	 ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes**		
Air filter present and filter cover attached	☐ **No** ☐ **Yes**		
Disinfection counter	Number:		
Wipe down with hospital approved cleaning solution	☐ **No** ☐ **Yes**		
Check overall condition of the Airvo	☐ **Very Good** ☐ **Good** ☐ **Poor**		
Keyboard/Panel buttons condition	☐ **Very Good** ☐ **Good** ☐ **Poor**		

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Action	Status	Date	Initials
Trolley/stand condition - casters	☐ **Very Good** ☐ **Good** ☐ **Poor**		
Display condition (scratches/pitting/brightness)	☐ **Very Good** ☐ **Good** ☐ **Poor**		
Power cord attached	☐ **No** ☐ **Yes**		
Basket attached	☐ **No** ☐ **Yes**		
High flow O2 meter and hose with DISS connection included	☐ **No** ☐ **Yes**		
Disinfection hose and filter attached	☐ **Very Good** ☐ **Good** ☐ **Poor**		
Air intake filter sent	☐ **No** ☐ **Yes** ☐ **N/A** Number:		
Air intake filter returned	☐ **No** ☐ **Yes** ☐ **N/A** Number:		
Circuits sent	☐ **No** ☐ **Yes** ☐ **N/A** Number:		
Circuits returned	☐ **No** ☐ **Yes** ☐ **N/A** Number:		
Comments for items marked as 'poor':			

Standard Biomedical Test	Pass	Date	Signature
Performed by:	☐ **No** ☐ **Yes**		
Biomedical Engineering Electrical Safety Test	**Pass**	**Date**	**Signature**
Performed by:	☐ **No** ☐ **Yes**		
Respiratory Therapy Department Functionality Test	**Pass**	**Date**	**Signature**
Performed by:	☐ **No** ☐ **Yes**		

This form was completed by:

Name:	
Position:	**Contact Number:**
Signature:	**Date:**

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